For CA Office Use Only
MCC:_____EIS:_____Access/MMIS:_____Letter sent:_____County:_____

Division of Medical Assistance
Provider Services
1985 Umstead Drive – 2501 Mail Service Center – Raleigh, N.C. 27699-2501
919-857-4017
www.dhhs.state.nc.us/dma

Carolina ACCESS Application for Participation- Primary Care Provider

Pages 1, 2 and 3 of this application must be completed and submitted with the Agreement containing an original signature. Report all changes to information provided in this application via the Carolina ACCESS Provider Information Change form, which is available on DMA's web site, http://www.dhhs.state.nc.us/dma/forms.html.

Is this application being sent to replace an existing Carolina ACCESS (CA) application/Agreement? **( ) Yes ( ) No**

Has this practice or any participating primary care provider in this practice (listed on Page 2 of this application) been sanctioned or terminated by either the Medicaid Program or the Carolina ACCESS Program? **( ) Yes ( ) No**

N.C. Medicaid Provider Number **(will become your CA provider number upon approval):** _____
Practice Name: _____
Street Address: _____
_____County:_____
Mailing Address (if different from the above street address): _____
_____
Telephone Number: (____)_____ After-Hours Phone Number: (____)_____
Fax Number: (____)_____ Email Address: _____
Identify a contact person for CA issues: Name: _____ Title: _____

Practice Specialty: _____
Is this practice a Rural Health Clinic? **( ) Yes ( ) No** Is the practice a Health Department? **( ) Yes ( ) No**
Is the practice a Federally Qualified Health Center? **( ) Yes ( ) No**

Indicate the desired maximum number of CA enrollees to be enrolled with this CA provider number: _____
Note: Upper limit is 2000 enrollees per participating provider listed on Page 2 of this application.
List any specific enrollment restrictions such as age and gender: _____
_____
Are new Medicaid patients accepted? **( ) Yes ( ) No** Is Medicare accepted? **( ) Yes ( ) No**

List all contiguous counties from which this practice will accept CA enrollees: _____
_____
_____

I am applying to participate as a primary care provider in the Carolina ACCESS program sponsored by the Department of Health and Human Services, Division of Medical Assistance.
Authorized Signature: _____Date: _____
Title/Position: _____

For DMA Office Use Only
Application approved by DMA: Yes ( ) No ( ) Effective Date:_____
DMA Authorized Signature: _____ Date: _____
Admin Entity: _____ Date: _____ Review Date: 1)_____ 2)_____ 3)_____

Carolina ACCESS
Application for Participation

List all Primary Care Providers (PCPs) in this practice applying for Carolina ACCESS (CA) participation at this time using the Medicaid provider number indicated in Page 1.

Full Names of PCPs to be listed with this CA Practice	Title (e.g. MD, FNP, PA) (Required)	Licensed Specialty (Required)	License Number (Required)	Individual Medicaid Provider Number (Required for Physicians)

Which providers listed above provide inpatient hospital care at a hospital participating with the NC Medicaid Program that is within thirty (30) miles or forty-five (45) minutes drive time from the practice?

Provider's name(s):	Name and location of hospital(s):	Ages admitted:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If none of the participating PCPs included on this application provides inpatient hospital care, or if the ages of all potential Carolina ACCESS enrollees are not addressed by the "ages admitted" in the above chart, then complete the attached Carolina ACCESS Hospital Admitting Agreement form and submit the document containing the original signatures with this Application for Participation.

Carolina ACCESS
Application for Participation

List Office Hours (i.e., Mon 8 a.m.-5 p.m., Tues 9 a.m.-1 p.m., Wed 8 a.m.-5 p.m., etc.): _____
_____
_____

Total number of hours that a provider is available to see patients at this location: _____
Note: 30 hours per week is the minimum requirement.

Indicate after-hours coverage (check all that apply):
Note: The practice shall not refer automatically to the Emergency Department (ED), nor shall calls to the hospital switchboard be referred directly to the ED.

- ❑ Answering Service
- ❑ Answering machine that gives the number of the provider to call
- ❑ Hospital operator who pages on-call provider
- ❑ Call forward or stay-on-line transferring
- ❑ Nurse Triage Service
- ❑ Other (please describe) _____
  _____

Indicate all interpretation services available.

- ❑ Oral Interpretation Services
  Note: Required for all non-English languages.
- ❑ TDD/TTY
- ❑ Sign Language
- ❑ Braille
- ❑ Other:_____
  _____

Indicate all preventive and ancillary services available to patients within the practice and without referral:
Note: To qualify, samples/specimens must be collected on-site, but may be sent out for testing.
(Check all that qualify.)

- ❑ Urinalysis
- ❑ Hemoglobin
- ❑ Hematocrit
- ❑ Health Check Screening Exam
- ❑ Standardized Written Developmental Screening (e.g. Ages and Stages, PEDS)
- ❑ Hearing Assessment (using electronic equipment, e.g. audiometer)
- ❑ Vision Assessment (e.g., Snellen Chart)
- ❑ Blood Lead Screening
- ❑ Hepatitis B Vaccine
- ❑ Diphtheria, Tetanus, Pertussis Vaccine (DTaP)
- ❑ Adult Preventive Annual Health Assessment Services
- ❑ Cervical Cancer Screening
- ❑ Tetanus Vaccine (Td)
- ❑ Tuberculin (TB) Testing (via PPD intradermal injection/Mantoux method)
- ❑ Influenza Vaccine
- ❑ Pneumococcal Vaccine (PCV)
- ❑ Haemophilus Influenzae Type b Vaccine (Hib)
- ❑ Inactivated Polio Vaccine (IPV)
- ❑ Measles, Mumps, Rubella Vaccine (MMR)
- ❑ Varicella Vaccine

For DMA Office Use Only

DMA Authorized Signature: _____Date: _____

STATE OF NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Agreement for Participation as a Primary Care Provider In North Carolina's Patient Access and Coordinated Care Program (Carolina ACCESS)

This agreement is between the State of North Carolina, Department of Health and Human Services Division of Medical Assistance, whose principal office is located in the City of Raleigh, County of Wake, State of North Carolina, hereinafter referred to as the "Division"

and _____ located in the
(name of primary care provider)

city of _____, county of _____, State of North Carolina or State of _____, hereinafter referred to as the "Contractor."

WHEREAS, the Division, as the single State agency designated to establish and administer a program to provide medical assistance to the indigent under Title XIX of the Social Security Act, is authorized to contract with health care providers for the provision of such assistance on a coordinated care basis;

NOW, THEREFORE, it is agreed between the DIVISION and the CONTRACTOR, as follows:

I. General Statement of Purpose and Intent

The Division desires to contract with providers willing to participate in the North Carolina Medical Assistance Program (Medicaid) to provide primary care directly and to coordinate other health care needs through the appropriate referral and authorization of Medicaid services. This program, Carolina ACCESS, applies to certain Medicaid recipients who may select or be assigned to the Contractor. This agreement describes the terms and conditions under which this agreement is made and the responsibilities of the parties thereto.

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Division and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Division and Contractor that any such person or entity, other than the Division or the Contractor, receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

II. General Statement of the Law

North Carolina's Patient Access and Coordinated Care Program (Carolina ACCESS) is a primary care patient coordination system implemented pursuant to Title XIX of the Social Security Act, and is subject to the provisions of North Carolina Statutes and North Carolina Administrative Code. This agreement shall be construed as supplementary to the usual terms and conditions of providers participating in the Medicaid program, except to the extent superseded by the specific terms of this agreement. The Contractor agrees to abide by all existing laws, regulations, rules, policies, and procedures pursuant to the Carolina ACCESS and Medicaid program.

The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, are governed by the laws of North Carolina. The Contractor, by signing this Contract, agrees and submits, solely for matters concerning this Contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the only venue for any legal proceedings shall be Wake County, North Carolina. The place of this Contract, and all transactions, agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to its validity, construction, interpretation, and enforcement, shall be determined.

III. Definitions-The following terms have the meaning stated for the purposes of this agreement:

Application- All forms and supplements to this agreement that the provider uses to apply for participation with the Carolina ACCESS program. This agreement shall be effective subject to approval of the Application by the Division.

Carolina ACCESS Policy- All policies and procedures required by this agreement and incorporated herein by reference are published in the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* which is published on the Division's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm. The web address for the Division's Internet Home Page is http://www.dhhs.state.nc.us/dma.

C.F.R- Code of Federal Regulations.

Contractor- The Primary Care Provider (PCP) entering into this agreement with the Division of Medical Assistance.

Division- The Division of Medical Assistance of the North Carolina Department of Health and Human Services.

Eligible Recipient- Medicaid recipients who are enrolled in the Carolina ACCESS program.

Enrollee- A Medicaid recipient who chooses or is assigned to a Carolina ACCESS primary care provider.

Group Practice/Center- A Medicaid participating primary care provider structured as a group practice/center which (1) is a legal entity (e.g., corporation, partnership, etc.), (2) possesses a federal tax identification (employer) number, and (3) is designated as a group by means of a Medicaid Group Provider number.

Management/Coordination Fee- The amount paid to the Contractor per member per month for each Carolina ACCESS recipient who has chosen or has been assigned to the Contractor.

Medicaid- The North Carolina Medical Assistance Program.

Medically Necessary- The term "Medical Necessity" is defined by Division policy.

Patient Care Coordination- The manner or practice of providing, directing, and coordinating the health care and utilization of health care services of enrollees with regard to those services as defined by Carolina ACCESS Policy that must be authorized by the primary care provider. If not provided directly, necessary medical services must be arranged through the primary care provider.

Potential Enrollee- A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific Primary Care Provider.

Preventive Services- Services rendered for the prevention of disease in adults and children as defined by Carolina ACCESS Policy.

Primary Care- The ongoing responsibility for directly providing medical care (including diagnosis and/or treatment) to an enrollee regardless of the presence or absence of disease. It includes health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, rendering continuous care to chronically ill patients, and referring the enrollee to another provider when necessary.

Primary Care Provider- The participating physician, physician extender (PA, FNP, CNM), or group practice/center selected by or assigned to the enrollee to provide and coordinate all of the enrollee's health care needs and to initiate and monitor referrals for specialized services when required.

Recipient Disenrollment- The deletion of the individual from the monthly list of enrollees furnished by the Division to the Contractor.

Women, Infants, and Children (WIC) Program- The Special Supplemental Food Program created by Congress in 1972 to meet the special nutritional needs of pregnant, breastfeeding and postpartum women, and of infants and children up to age five (5).

IV. Functions and Duties of the Contractor

In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statues and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations.

The Contractor is and shall be deemed to be an independent Contractor in the performance of this Contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or shall secure at its own expense, all personnel required in performing the services under this Agreement. Such employees shall not be employees of, or have any individual contractual relationship with, the Division.

The Contractor shall not subcontract any of the work contemplated under this Contract without prior written approval from the Division. Any approved subcontract shall be subject to all conditions of this contract. Only the subcontractors specified in the Contractor's application are to be considered approved upon award of the contract. The Contractor shall be responsible for the performance of any subcontractor. The Division shall not be responsible to pay for work performed by unapproved subcontractors.

The Carolina ACCESS Contractor agrees to do the following:

4.1 Accept enrollees pursuant to the terms of this agreement and be listed as a primary care provider in the Carolina ACCESS program for the purpose of providing care to enrollees and managing their health care needs.

4.2 Provide Primary Care and Patient Care Coordination services to each enrollee in accordance with the provisions of this agreement and the policies set forth in Medicaid provider manuals and Medicaid bulletins and as defined by Carolina ACCESS Policy.

4.3 Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Carolina ACCESS Policy. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

4.4 Provide direct patient care a minimum of 30 office hours per week or as defined by Carolina ACCESS Policy.

4.5 Provide preventive services as defined by Carolina ACCESS Policy.

4.6 Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees as defined by Carolina ACCESS Policy.

4.7 Maintain a unified patient medical record for each enrollee following the medical record documentation guidelines as defined by Carolina ACCESS Policy.

4.8 Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record. Provide the authorization number (Carolina ACCESS provider number) to the referral provider either in writing or by telephone as defined by Carolina ACCESS Policy.

4.9 Transfer the Carolina ACCESS enrollee's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request.

4.10 Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Carolina ACCESS Policy.

4.11 Refer for a second opinion as defined by Carolina ACCESS policy.

4.12 Review and use all enrollee utilization and cost reports provided by the Carolina ACCESS Program for the purpose of practice level utilization management and advise the Division of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Carolina ACCESS Policy. A signed *Provider Confidential Information and Security Agreement* is required for online access to these reports. The form is published on the Division's web page at http://www.dhhs.state.nc.us/dma.

4.13 Participate with Division utilization management, quality assessment, and administrative programs.

4.14 Provide the Division or its duly authorized representative or the Federal government unlimited access (including on site inspections and review) to all records relating to the provision of services under this agreement as required by Medicaid policy and 42 C.F.R. 431.107.

4.15 Refer potentially eligible enrollees to the WIC Program with the enrollee's consent to the release of relevant medical record information.

4.16 Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the North Carolina Physicians Advisory Group.

4.17 Notify the Division of any and all changes to information provided on the initial application for participation.

4.18 Give written notice of termination of this contract, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis.

4.19 Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

4.20 Refrain from discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

4.21 Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

4.22 Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.

4.23 Receive prior approval from the Division of any marketing materials prior to distribution. Marketing materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits. Marketing materials shall not make any assertion or statement that the Contractor is endorsed by CMS, the Federal or State government or similar entity.

4.24 Refrain from door-to-door, telephonic or other 'cold-call' marketing; engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the Contractor, its marketing representatives, or the Division.

4.25 Refrain from knowingly engaging in a relationship with the following:

- an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
- an individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- As a director, officer, partner of the Contractor,
- A person with beneficial ownership of more than five percent (5%) or more of the Contractor's equity; or,
- A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's contractual obligation with the Division.

4.26 Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends.)

V. Functions and Duties of the Division

The Division agrees to do the following:

5.1 List the Contractor's name as a primary care provider in the Carolina ACCESS program.

5.2 Pay the Contractor on a fee-for-service basis in accordance with the Medicaid fee schedule and billing guidelines. Any monthly management/coordination fee paid in addition to the fee-for-service Medicaid payments will be paid per member per month, subject to the maximum number of enrollees under paragraph 6.1.A. The amount of the management/coordination fee, if any, may be adjusted according to practice performance parameters as defined by the Division. Multiple providers within a group practice are considered a single entity for purposes of the management/coordination fee.

5.3 Provide the Contractor with a monthly list of enrollees who have selected or have been assigned to him/her for the purpose of managing their health care needs.

5.4 Provide training and technical assistance regarding the Carolina ACCESS program.

5.5 Provide the Contractor with periodic utilization and cost reports.

5.6 Gather and analyze data relating to service utilization by enrollees to determine whether Contractors are within acceptable Carolina ACCESS peer comparison parameters.

5.7 Publish the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* and the Medicaid General and Special Bulletins on the Division's website at http://www.dhhs.state.nc.us/dma. All such policies, procedures, Medicaid provider bulletins and manuals are incorporated into this agreement by reference.

5.8 Provide an ongoing quality assurance program to evaluate the quality of health care services rendered to enrollees.

5.9 Provide program education to all enrollees through the local Department of Social Services or duly authorized representatives during eligibility reviews or within a reasonable timeframe. The recipient will receive accurate oral and written information needed to make an informed decision on whether to enroll.

5.10 Provide potential enrollees and enrollees with the *Carolina ACCESS Medicaid Managed Care Recipient Handbook* that contains program information including enrollee rights and protections, program advantages, enrollee responsibilities, complaint and grievance instructions. The *Carolina ACCESS Medicaid Managed Care Recipient Handbook* is also published on the Division's website at http://www.dhhs.state.nc.us/dma/ca/careciphand.htm.

5.11 Notify enrollees that oral interpretation is available for any language and written material is available in prevalent languages and how to access these services.

5.12 Provide written materials that use easily understood language and format. Written material will be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

5.13 Inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

5.14 Provide marketing materials to potential enrollees.

VI. General Terms and Conditions

6.1 Recipient Enrollment and Disenrollment

A. Recipient Enrollment

1. The Contractor must accept individuals in the order in which they apply without restriction up to the limits set by the contract. The Contractor may specify a limit on the number of enrollees on the Carolina ACCESS Application for Participation subject to the following terms and conditions:
   - Maximum enrollment is set at 2,000 enrollees per physician or physician extender unless otherwise approved by the Division.
   - Notwithstanding the enrollment limits specified above, the Contractor may receive an enrollment that slightly exceeds these limits due to the nature and timing of the enrollment process.
   - The Contractor may set enrollment criteria on the Application, but must accept recipients who meet the enrollment criteria up to the limit specified.
   - The Contractor may change the enrollee limit by notifying the Division.
   - The Contractor must restrict enrollment to recipients who reside sufficiently near the delivery site to reach that site within a reasonable time using available and affordable modes of transportation.

B. Recipient Choice

1. Eligible Recipients may choose from among participating Contractors who are available to their county of residence when those Contractors' enrollment limits have not been exceeded.
2. Eligible Recipients who do not choose a primary care provider shall be assigned to an appropriate participating provider available to their county of residence based on historic usage, location and/or randomly by rotating assignment.
3. All recipient enrollments, disenrollments and changes are effective on the first day of the month, pursuant to processing deadlines and will be indicated on the Enrollment Report.

C. Recipient Disenrollment

1. Enrollees shall be permitted to change primary care providers according to Carolina ACCESS Policy. Transfer of medical records is addressed in Section 4.9 of this agreement.
2. The Contractor may request the disenrollment of an enrollee for good cause as defined by Carolina ACCESS Policy.
3. The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular enrollee or other enrollees).
4. The *Carolina ACCESS Medicaid Managed Care Recipient Handbook* includes complaint and grievance instructions and is provided to potential enrollees and enrollees. This handbook is also published on the Division's website at http://www.dhhs.state.nc.us/dma/ca/careciphand.htm.
5. If the Division fails to make a disenrollment determination so that the recipient can be disenrolled no later than the first day of the second month following the month in which the recipient or the Contractor files the request, the disenrollment is considered approved.

6.2 Contract Violation Provisions

The failure of a Contractor to comply with the terms of this agreement may result in the following sanctions by the Division:

A. Limiting member enrollment with the Contractor.

B. Withholding all or part of the Contractor's monthly Carolina ACCESS management/coordination fee.

C. Referral to DMA Program Integrity Unit for investigation of potential fraud or quality of care issues.

D. Referral to North Carolina Medical Board.

E. Termination of the Contractor from the Carolina ACCESS program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Division based on the severity of the agreement violation. The Division makes the determination to initiate sanctions against the Contractor. The Contractor will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Division determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the notice. If the Contractor disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Carolina ACCESS Policy.

Failure of the Division to impose sanctions for an agreement violation does not prohibit the Division from exercising its rights to do so for subsequent agreement violations.

Federal Financial Participation (FFP) is not available for amounts expended for Contractors excluded by Medicare, Medicaid or State Children's Health Insurance Program (SCHIP), except for emergency services.

6.3 Application Process

The Contractor will complete an Application to submit with the signed agreement for review and approval by the Division.

6.4 Exceptions to the Agreement

The Division may approve exceptions to this agreement if, in the opinion of the Division, the benefits of the Contractor's participation outweigh the Contractor's inability to comply with a portion of this agreement.

In order to amend this agreement, the Contractor shall submit a written request to the Division for consideration for exception from a specific agreement requirement. The request shall include the reasons for the Contractor's inability to comply with this agreement requirement. The request shall be submitted at the time this agreement is submitted to the Division for consideration. Approval of the Application constitutes acceptance of the request for an exception.

6.5 Transfer of Agreement

This agreement may not be transferred.

6.6 Contract Termination

This agreement may be terminated by either party, with cause, or by mutual consent, upon at least thirty (30) days written notice delivered by certified mail with return receipt requested and will be effective only on the first day of the month, pursuant to processing deadlines.

The Division under the following conditions may terminate this agreement immediately:

1. In the event that state or federal funds that have been allocated to the Division are eliminated or reduced to such an extent that, in the sole determination of the Division, continuation of the obligations at the levels stated herein may not be maintained. The obligations of each party shall be terminated to the extent specified in the notice of termination immediately upon receipt of notice of termination from the Division; or
2. If the Contractor (a) is determined to be in violation of terms of this agreement, or applicable federal and state laws, regulations, and policy, and/or (b) fails to maintain program certification or licensure; or
3. Upon the death of the Contractor, the sale of the Contractor's practice, or termination of participation as a Medicaid or Medicare provider; or
4. In the event of conduct by the Contractor justifying termination, including but not limited to breach of confidentiality, or any other covenant in this agreement, and/or failure to perform designated services for any reason other than illness.

The Contractor must supply all information necessary for reimbursement of outstanding Medicaid claims.

VII. Effective Date and Duration

This agreement shall become effective on _____ and remain in effect until amended or terminated pursuant to the terms of this agreement.

(to be completed by DMA office staff)

VIII. Signatories:

North Carolina Department Of Health and Human Services/Division Of Medical Assistance	**Carolina ACCESS Provider Contractor**
_____	_____
(Authorized Representative Division of Medical Assistance)	**(Signature -Authorized Official)**
	_____
	(Typed or Printed Name)
_____	_____
(Title)	**(Title)**
	_____
	(Provider Number)
_____	_____
(Date)	
	_____
	(Mailing Address)
	_____
	(Date)

Carolina Access Web Portal Project

Last Updated: Wednesday, March 31, 2004

Attention: Carolina ACCESS Primary Care Providers

Carolina ACCESS Enrollment, Referral, Emergency Room, and Utilization Reports

The Division of Medical Assistance's Managed Care Section is beginning the process of replacing paper copies of the Carolina ACCESS Enrollment, Referral, Emergency Room, and Quarterly Utilization reports with web-based versions of the reports. Each Carolina ACCESS Primary Care Provider (PCP) must complete the Provider Confidential Information and Security Agreement and return it to gain access to these web-based versions. Each approved user will receive log in information via e-mail. This e-mail will include a link to the **DMA Information and Report System** http://reports.ncmedicaid.com where the user will have access to the following:

- Security Contact Administration
- On-line Training
- Access to View Reports
- Technical Support
- Additional Information (related sites)

Instructions for Completing the Provider Confidential Information and Security Agreement

Only one Provider Confidential Information and Security Agreement shall be active for each enrolled Carolina ACCESS Primary Care Provider. If a practice is enrolled as a group, the practice must select one person as the Security Contact for the group. Likewise, if individual providers in a group practice have chosen to enroll with Carolina ACCESS individually, a Provider Confidential Information and Security Agreement must be completed for each individual provider enrolled. Providers MAY choose to select ONE Security Contact person for multiple practices or for more than one Carolina ACCESS provider number, but a form containing original signatures must be submitted for each active Carolina ACCESS provider number. The Security Contact person will be given the ability to add other users in the practice or network to the system so that they can access reports. The provider is responsible for the oversight of the Security Contact person's role.

1. Carolina ACCESS Practice Provider's Enrollment Number:

   The provider number on the Provider Confidential Information and Security Agreement must be the active Carolina ACCESS provider number because it drives the separation of the reports. Some of these reports include private health information (PHI) and are covered under the HIPAA Privacy Act for the patients listed on the reports. It is very important that a user is not granted access to a Provider Number he or she has not been approved to access.

2. Carolina ACCESS Practice Name:

   Because the Carolina ACCESS practice name is used for verification when approving a user access to provider reports, it is important to list the practice name as it appears on the Carolina ACCESS application.

3. Carolina ACCESS Practice Address:

   The Carolina ACCESS practice address is also used for verification when approving a user access to Provider reports and must agree with the information provided on the Carolina ACCESS application.

4. Provider's Security Contact Name (First, Middle, Last):

   a) Security Contact Name must be printed clearly and listed exactly as it is listed on the Security Contact User's Social Security Card.

   b) The Social Security Administration is working to develop a (Pass/Fail) one-time verification whose <u>sole</u> purpose is to match a user name with a Social Security Number. This verification <u>will not</u> be used in any other manner. Private information related to the Social Security Number <u>will not</u> be accessible or stored in any way. User's Social Security Numbers <u>will not</u> be posted anywhere for State or Provider Access. This process has been created to assure the validity of all users who will access PHI reports.

   c) Social Security Numbers will be linked to a user in a secure database on site. User Names and Social Security Numbers will not be stored on any web site or shared servers. This process is being used to protect PHI system access as well as to protect the user.

   d) There is a possibility of approximately 3,000 to 5,000 users involved with the Carolina Access Web Portal release. The Carolina Access Project is the first of many projects providing this type of information concerning PHI across the State of North Carolina.

   e) This method of "identity management" (i.e., linking user name with SSN within a secure database) is extremely secure and reliable and is most assuredly in the best interest of both the State <u>and</u> the Provider.

5. Security Contact Birth Date:

   Birth Date is additional information required for Provider Employee distinction.

6. Provider's Security Contact Signature and Date:

   The original signature of the designated Security Contact person and date are required to keep on file for Security State and Federal audits.

7. Provider Security Contact Person's Social Security Number:

   Please see number (4) above. The User is protecting the practice by providing us with this information. With this information, we can assure that unauthorized access to the provider's reports and to patient PHI is eliminated. Accessing PHI via a Web Portal is a great step towards future Heath Care if done so in a secure environment.

   Because sending passwords via e-mail is against HIPAA Security Rules, the Security Contact person will receive an email containing the assigned User ID and a message that the initial temporary password is the Security Contact person's social security number. At initial login, the user will be forced to change their password for additional security. DMA grants the Security Contact access to the appropriate provider reports electronically and <u>no one else</u> sees the user's SSN.

8. Provider Security Contact Person's e-mail

   We require an e-mail address so the Security Contact Person will be able to receive the log on information. If a Provider has Internet access in the office, the user could set up an address to be used only for work related purposes. In the future, the total DMA Information and Report System users could reach the tens of thousands and the State must make this process as electronic as possible. Once the user has been approved and access given, they will receive an email with information about the DMA Information and Report System and a link to this portal.

9. Provider Witness of Security Contact Signature and Date:

   The actual signature of the Carolina ACCESS Primary Care Provider and date signed is required to verify the provider has authorized this user to access the provider's reports. The signature must be that of an active Carolina ACCESS PCP listed on the Carolina ACCESS application for the corresponding practice and Carolina ACCESS provider number. This signature also authorizes the Security Contact person to set up or modify access of other users in the office. The appropriate signature is required for State and Federal Audits.

10. DMA Sponsor and Date (DHHS OFFICE USE ONLY):

    The DMA Sponsor who approves the Carolina ACCESS Contract or change in Provider Security Contact Person is required to sign and date on this line for State and Federal Audits.

NC Division of Medical Assistance, Department of Health and Human Services

Provider Confidential Information and Security Agreement

The Provider understands that:

The identity of Medicaid applicants and recipients including, but not limited to, Medicaid identification numbers, names, and related medical health claim information is confidential protected health information and may only be disclosed in accordance with DHHS, state, and federal laws and regulations.

Each provider must delegate a staff member as the Security Contact Person who will be responsible for requesting user access to automated reports and resources. The Security Contact Person or Provider must also notify the Division of Medical Assistance (DMA) of any change in job duties, termination of employment, or leave of absence that would require immediate action for a user.

All passwords assigned to the provider and designated users for access to automated reports and resources are confidential. Logon identifiers and passwords uniquely identify the user. It is a violation of federal and state laws and regulations and the Department of Health and Human Services and DMA system security policy to divulge or share logon identifiers and passwords with another person.

To protect confidential data, the provider and designated users must safeguard and protect electronic data transactions that transmit protected health information about Medicaid applicants and recipients. The provider and designated users are responsible for ensuring that reasonable efforts must be made to protect the confidentiality of individually identifiable health information in all situations including e-mail, regular mail, fax, etc. All users with approved access to multiple Provider reports are responsible for accessing the data at the location specified by the approving provider.

DMA will retain this original signed Agreement in the provider's file. Providers should copy and retain a copy of this agreement in their files.

The signature of the designated Provider Security Contact person and the Provider witness signifies that the Provider and the Security Contact person have read this Agreement and understand the obligations to protect confidential protected health information. The Provider further agrees that the rules and regulations pertaining to privacy and security mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 P.L. 104-91, as amended apply to the terms of this agreement and any agreements or practices executed by DMA to comply with HIPAA requirements.

Please Check Here if this is a CHANGE for your Designated Security Contact ☐

Carolina ACCESS Practice Provider's Enrollment Number _____

Please print the Carolina ACCESS Practice Name: _____

Please print the Carolina ACCESS Practice Address: _____

Print Provider's Security Contact Name (First, Middle, Last): _____

Print Security Contact Birthdate: _____

Provider's Security Contact Signature: _____ Date: _____

Provider Security Contact Person's Social Security Number: _____

Provider Security Contact Person's e-mail _____

Provider Witness of Security Contact Signature _____ Date: _____

DMA Sponsor (DHHS OFFICE USE ONLY) _____ Date: _____

CAROLINA ACCESS HOSPITAL ADMITTING REQUIREMENT

The establishment of a continuous and comprehensive patient/provider relationship is an essential component of Carolina ACCESS. Therefore, Carolina ACCESS (CA) primary care providers (PCPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addresses the needs all enrollees or potential enrollees. If the CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the North Carolina Medicaid program, then the *Carolina ACCESS Hospital Admitting Agreement* form must be submitted to DMA Provider Services to address this requirement for participation. To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the *Carolina ACCESS Hospital Admitting Agreement* form, which serves as the written agreement between the two parties. **IF the Carolina ACCESS provider has entered into a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the application for participation or when a change occurs regarding the provider's management of inpatient hospital admissions.**

> **Note:** A *formal arrangement* is defined as a voluntary agreement between the Carolina ACCESS primary care provider and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Carolina ACCESS enrollee throughout the inpatient stay.

The following Carolina ACCESS requirements regarding inpatient hospital care must be met:

1. Under the conditions stated above, the CA PCP must provide inpatient hospital care, or have a signed *Carolina ACCESS Hospital Admitting Agreement* form on file at DMA.
2. All ages of the provider's CA enrollees or potential enrollees must be covered by the inpatient hospital care or formal arrangement for inpatient hospital care or a combination of the two.
3. If the *Carolina ACCESS Hospital Admitting Agreement* form is utilized, the Agreement(s) must be between the CA PCP and one or more of the following:
   - a physician
   - a group practice
   - a hospitalist group
   - a physician call group

   Note: The above providers must be enrolled as NC Medicaid providers, but it is not necessary that they be enrolled as Carolina ACCESS providers. Admissions through unassigned hospital-based call groups do <u>not</u> meet this requirement.
4. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five (45) minutes drive time from the CA PCP's practice.
   Note: If there is no hospital that meets the above geographical criteria, *the hospital geographically closest to the CA PCP's (Contractor's) practice will be accepted.*
5. Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.
   Note: For more information refer to the *Agreement for Participation as a Primary Care Provider in North Carolina's Patient Access and Coordinated Care Program*, Section IV, 6.4.

Questions regarding hospital admitting privileges may be directed to DMA Managed Care by calling 919-857-4022.

Division of Medical Assistance
Provider Services
1985 Umstead Drive – 2501 Mail Service Center – Raleigh, N.C. 27699-2501
919-857-4017
www.dhhs.state.nc.us/dma

Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement

This form is to be completed only if the Carolina ACCESS (CA) Primary Care Provider (PCP) does not provide inpatient hospital care that addresses the needs of the CA enrollees or potential enrollees.

Carolina ACCESS Primary Care Provider or Applicant:

(First Party Section)

CA PCP Applicant Name:_____ CA Provider Number:_____

Mailing Address: _____

_____

Contact Person: _____ Telephone Number: _____

To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement form. This form serves as a formal written agreement established between the two parties as follows:

- The Carolina ACCESS Primary Care Provider is privileged to refer Carolina ACCESS patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
- The second party will arrange coverage for Carolina ACCESS enrollee admissions during their vacations.
- Either party may terminate this agreement at any time by giving written 30 days advance notice to the other party or by mutual agreement.
- The Carolina ACCESS Primary Care Provider will notify Carolina ACCESS in writing of any changes to or terminations of this agreement.
- The Carolina ACCESS Primary Care Provider will provide the second party with the appropriate payment authorization number.

Physician and/or Group Agreeing to Cover Hospital Admissions For Above Carolina ACCESS Primary Care Provider Applicant:

(Second Party Section)

Physician/Group Name: _____ Medicaid Provider Number: _____

Mailing Address: _____

_____

Specialty: _____ Ages Admitted: _____

Hospital Affiliation(s) and Location(s): _____

_____

Contact Person: _____ Telephone Number: _____

Authorized Signature: _____ Date: _____

HEALTH CHECK AGREEMENT BETWEEN PRIMARY CARE PROVIDER (PCP) AND THE LOCAL HEALTH DEPARTMENT

For recipients of Medicaid, birth to age 21, the Health Check Medical Screening Exam is required as a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the health check exam, all of which are required in the Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in the attached document "Health Check Screening Components."

WHAT IS AN AGREEMENT FOR HEALTH CHECK?

If a Carolina ACCESS PCP cannot or chooses not to perform the comprehensive health check screenings, this agreement allows the PCP to contract with the Health Department serving the PCP's county to perform the screenings for enollees in the birth to 21 year age group.

The agreement requires the following:

- The Health Department must provide the results of the exam to the PCP within 30 days unless follow-up is necessary, in which case, the Health Department must communicate the results of the screening within 24 hours.
- The PCP is required to coordinate any necessary treatment or follow-up care as determined by the screening.
- Under this agreement, the health department must perform all health check components at the time of the appointment unless circumstances require an appointment be rescheduled.

If the PCP chooses to utilize this agreement in order to meet this Carolina ACCESS requirement for participation, the agreement containing the original signatures of the PCP or the authorized representative and the Director of the Health Department or an authorized representative must be submitted to the Division of Medical Assistance (DMA). The PCP must keep a copy of this agreement on file.

This agreement can be entered into or terminated at any time by the PCP or the Health Department. DMA must be notified immediately of any change in the status of the agreement.

Questions regarding this agreement or health check requirements can be made to DMA Managed Care at 919-857-4022 or by contacting the regional Managed Care Consultant.

AGREEMENT BETWEEN PRIMARY CARE PROVIDER AND HEALTH DEPARTMENT TO PROVIDE HEALTH CHECK SERVICES TO CAROLINA ACCESS PATIENTS

In order to provide coordinated care to those children who are enrolled in Carolina ACCESS and obtain primary care services from _____ and Health Check services and immunizations from _____ County Health Department (CHD), the undersigned agree to the following provisions.

Primary Care Provider agrees to:

1. Refer Carolina ACCESS patients to the CHD for Health Check appointments. If the patient is in the office, the physician/office staff will assist the patient in making a Health Check appointment with the CHD.

2. Maintain, in the office, a copy of the physical examination and immunization records as a part of the patient's permanent record.

3. Monitor the information provided by the CHD to assure that children in the Carolina ACCESS program are receiving immunizations as scheduled and counsel patients appropriately if they are noncompliant with well child visits or immunizations.

4. Review information provided by the CHD and follow up with patients when additional services are needed.

5. Provide the Division of Medical Assistance Managed Care Section at least thirty (30) days advance notice if the Primary Care Provider (PCP) and/or the CHD wishes to discontinue this Agreement.

The Health Department agrees to:

1. Provide age appropriate Health Check examinations and immunizations within ninety (90) days of the request for patients who are referred by the PCP or are self-referred.

2. Send Health Check physical examination and immunization records monthly to the Primary Care Provider.

3. Notify the Primary Care Provider of significant findings on the Health Check examination within twenty-four (24) hours. Allow the Primary Care Provider to direct further referrals for specialized testing or treatment.

4. Provide the Division of Medical Assistance Managed Care Section thirty (30) days advance notice if the Primary Care Provider and/or the CHD wishes to discontinue this Agreement.

_____ _____ _____
Signature of Primary Care Provider or Authorized Official Date PCP Medicaid Provider #

_____ _____
Printed Name of Provider or Authorized Official Provider Group Name (if applicable)

_____ _____
Signature of Health Department Director/Designee Date

_____ _____
Printed Name of Health Department Director/Designee Health Dept. Provider Number

cc: DMA, Managed Care Section, Program Administrator (7/98)

DMA Managed Care Consultants
As of August 1, 2006

Region 1 **Lisa Catron** 828-689-4075 Tele 919-715-0844 Fax	**Region 2** **LaRhonda Cain** 919-647-8190 Tele 919-715-0844 Fax	**Region 3** **Lisa Gibson** 919-319-0301 Tele 919-319-0551 Fax	**Region 4** **Chris Lucas** 919-647-8176 Tele 919-715-0844 Fax	**Region 5** **Jerry Law** 252-321-1806 Tele 252-321-1806 Fax	**Region 6** **Rosemary Long** 910-738-7399 Tele 910-738-7349 Fax
Avery	Alexander	Davidson	Alamance	Beaufort	Bladen
Buncombe	Alleghany	Davie	Caswell	Bertie	Brunswick
Burke	Anson	Forsyth	Chatham	Camden	Carteret
Cherokee	Ashe	Guilford	Durham	Chowan	Columbus
Clay	Cabarrus	Hoke	Franklin	Currituck	Craven
Cleveland	Caldwell	Montgomery	Granville	Dare	Cumberland
Graham	Catawba	Moore	Harnett	Edgecombe	Duplin
Haywood	Gaston	Randolph	Johnston	Gates	Jones
Henderson	Iredell	Richmond	Lee	Greene	Lenoir
Jackson	Lincoln	Rockingham	Orange	Halifax	New Hanover
Macon	Mecklenburg	Scotland	Person	Hertford	Onslow
Madison	Rowan	Stokes	Vance	Hyde	Pamlico
McDowell	Stanly	Surry	Wake	Martin	Pender
Mitchell	Union	Wilkes	Warren	Nash	Robeson
Polk	Watauga	Yadkin	Wilson	Northampton	Sampson
Rutherford				Pasquotank	Wayne
Swain				Perquimans	
Transylvania				Pitt	
Yancey				Tyrrell	
				Washington	

Adult Preventive Annual Health Assessment Services
North Carolina Medicaid Program

Introduction
Adult Medicaid enrollees who are 21 years of age or older may receive one preventive annual health assessment per year. The Preventive Annual health Assessment was formerly known as an Adult Health Screening.

Definition
A Preventive Annual Health Assessment provides preventive health care for adults through annual health assessments with the expectation that it will prevent serious illness through early detection and treatment.

Preventive Annual Health Assessments are delivered through local health department clinics, rural health centers, Federally Qualified Health Centers, Carolina ACCESS Primary Care Providers serving adults and other physicians in private practices. Physician assistants, nurse practitioners and nurse midwives (for adult women) are also permitted to perform the screening evaluations. Registered nurses employed by the health department who have successfully completed the Guilford Adult Health Physical Assessment Course may also provide this service.

Prior Approval
No prior approval is needed.

Specialized Guidelines
Preventive Annual Health Assessments are Evaluation and Management visits which provide an annual health assessments for eligible enrollees age 21 and above. The extent and focus of the services depend on the age of the individual. Justification for omitting a required component from a screening must be documented in the medical record. **The required components of an initial Adult Annual Health Assessment for a new patient are as follows:**

1. A comprehensive health history which includes present, past and family history. The history should be obtained on the initial visit, then updated as needed. The elements below are suggested for use as an initial baseline history.
    a. Present history:
        - Health behaviors that are potential risk factors; alcohol, drug and tobacco use; highway safety (seatbelt and helmet use); sexual practices (contraception, sexually transmitted diseases); family violence; exercise and dietary habits.
        - Medication
        - Symptoms (review of symptoms)
    b. Past history:
        - Immunizations: diphtheria, tetanus, polio, rubella, influenza, pneumococcal, and hepatitis vaccines
        - Significant illness
        - Blood transfusions
    c. Family history
    d. Environmental exposures: sun or radiation exposures, exposure to known carcinogens, noise.

2. A comprehensive unclothed physical examination must be performed and includes:
    a. Measurements to be recorded each visit: height, weight, blood pressure, pulse
    b. A complete physical inspection to include skin, oral cavity, EENT, heart, abdomen, breast (female), pelvic, rectal, testicular (male), and extremities

3. Gender and age appropriate laboratory/diagnostic procedures.

4. Counseling/anticipatory guidance/risk factor reduction interventions including:
    a. Risk factors for cancer, hypertension, cardiovascular disease, trauma, communicable diseases, and addictive behaviors discussed and documented
    b. Individualized health improvement plan established in consultation with patient
    c. Abnormalities found in screening discussed with the patient and plans for further evaluation made
    d. Self examination skills taught = breast, testes, skin

The required components of a periodic preventive annual health assessment also include a comprehensive history and examination, the ordering of gender and age appropriate laboratory/diagnostic procedures, and counseling/anticipatory guidance/risk factor reduction interventions but the screening is performed for an **established** patient.

Limitations

Adults 21 years of age or older may receive one preventive annual health assessment every 365 days. The following components may be billed as separate procedures when performed as part of the preventive annual health assessment.

Injectable medications and ancillary studies for laboratory and radiology are the only CPT codes that are separately billable when an annual health assessment is performed.

Special Billing Instructions

The Adult Preventive Annual Health Assessment must be billed on a HCFA-1500 claim form using a diagnosis code of V700 and one of the preventive codes contained in the table below. Medicaid enrollees receiving an Adult Preventive Medicine Annual Health Assessment are responsible for a $3.00 copayment for the visit.

CODE	DESCRIPTION	AGE	GUIDELINES
99385	Initial preventive medicine	21 through 39 years	Health Screening
99386	Initial preventive medicine	40 through 64 years	Health Screening
99387	Initial preventive medicine	65 years and older	Health Screening
99395	Periodic preventive medicine, Established patient	21 through 39 years	Health Screening
99396	Periodic preventive medicine, Established patient	40 through 64 years	Health Screening
99397	Periodic preventive medicine, Established patient	65 years and older	Health Screening

The following information is extracted from the April 2003 North Carolina Medicaid Special Bulletin, Health Check Billing Guide and is available in its entirety at the following website:
http://www.dhhs.state.nc.us/dma/bulletin/pdfbulletin/0403specbull.pdf.

HEALTH CHECK SCREENING COMPONENTS

The Health Check Program is a preventive care program for Medicaid-eligible children ages birth through 20. **A Health Check Screening is the only well child preventive visit reimbursable by Medicaid**. **All Health Check components are required and are to be documented in the medical record. Each screening component is vital for measuring a child's physical, mental, and developmental growth.** Recipients are encouraged to receive their comprehensive health checkups and immunizations on a regular schedule. A complete Health Check screening consists of the following age-appropriate components, which must be performed and documented at each visit **unless** otherwise noted.

- **Comprehensive unclothed physical examination**
- **Comprehensive health history**
- **Nutritional assessment**
- **Anticipatory guidance and health education**
- **Measurements, blood pressure, and vital signs**
  Blood pressure is required to become a part of the exam at age 3.
- **Developmental screening, including mental, emotional, and behavioral**
  Perform age-appropriate evaluation at **each** screening. In addition, three written developmental assessments should be performed: the first by 12 months, the second by 24 months, and the third by 60 months of age.
- **Immunizations**
  Federal regulations state that immunizations are to be provided at the time of screening if they are needed.
- **Vision and hearing assessments**
  Health Check follows the Recommendations for Preventive Pediatric Health Care from the American Academy of Pediatrics for hearing and vision assessments. The Recommendations for all screening components may be accessed at http://www.aap.org/policy/re9939.html.

  In accordance with the periodicity schedule and the Recommendations for Preventive Pediatric Health Care, **objective** vision assessment (i.e., Snellen chart) is required at ages 3 years, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

  In accordance with the periodicity schedule and the Recommendations for Preventive Pediatric Health Care, objective hearing assessments **using electronic equipment** (i.e., audiometer) must be performed at birth, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

  If the required vision and/or hearing screenings cannot be performed during a periodic visit due to blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.
- **Dental screenings**
  A dental referral is required for every child beginning at 3 years of age. An oral screening performed during a physical examination is not a substitute for examination through direct referral to a dentist. The initial dental referral must be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. When any screening indicates a need for dental services at an earlier age (i.e., baby bottle caries), referrals must be made for needed dental services and documented in the patient's record. The periodicity schedule for dental examinations is not governed by the schedule for regular health screenings.

  Note: Dental varnishing is not a requirement of the Health Check screening exam. Providers may bill for dental varnishing and receive reimbursement in addition to the Health Check screening. Providers are to utilize the codes and billing guidelines as indicated in the August 2002 general Medicaid bulletin. Bulletins are available on the Division of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma.

- **Laboratory procedures**
  Includes hemoglobin or hematocrit, urinalysis, sickle cell, tuberculin skin test, and lead screening.

  Note: When these laboratory tests are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

  Hemoglobin or hematocrit
  Hemoglobin or hematocrit must be measured once during infancy (between the ages of 9 and 12 months) for all children and once during adolescence for menstruating adolescent females. An annual hemoglobin or hematocrit screening for adolescent females (ages 11 to 21 years) should be performed if any of the following risk factors are present: moderate to heavy menses, chronic weight loss, nutritional deficit or athletic activity.

  The Special Supplemental Nutritional Program for Women, Infants and Children (WIC) has specific time frames for hematocrit/hemoglobin testing. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information. For more information on guidelines and time frames, call the local WIC office.

  Urinalysis
  Urinalysis must be performed during the 5-year-old periodic screening as well as during periodic screenings for all sexually active males and females.

  Sickle cell testing
  North Carolina hospitals are required to screen all newborns for sickle cell prior to discharge. If a child has been properly tested, this test need not be repeated. **Results must be documented in the child's medical record.** If the test results of the newborn sickle cell screening are not readily available, contact the hospital of birth. An infant not tested at birth should receive a sickle cell test prior to 3 months of age.

  Tuberculin testing
  Reviewing perinatal histories, family and personal medical histories, significant events in life, and other components of the social history will identify children/adolescents for whom TB screening is indicated. If none of the screening criteria below are present, there is no recommendation for routine TB screening.

  The North Carolina TB Control Branch is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

  Tuberculin testing should be performed as clinically indicated for children/adolescents at increased risk of exposure to tuberculosis, **via Purified Protein Derivative (PPD) intradermal injection/Mantoux method** – not Tine Test.

  Criteria for screening children/adolescents for TB (per the NC TB Control Branch) are:

  1. Children/adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms.

  2. Do a **baseline screen** when these children/adolescents present for care.

     a. Foreign-born individuals arriving within the last five years from Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand and countries in Western Europe.

     b. Children/adolescents who are migrants, seasonal farm workers, or are homeless.

     c. Children/adolescents who are HIV-infected.

     d. Adolescents who inject illicit drugs or use crack cocaine.

  Subsequent TB skin testing is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

In addition to the TB Control Branch criteria:
A TB screening performed as a part of a Health Check screening cannot be billed separately.

Lead Screening

Federal regulations state that all Medicaid-enrolled children are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should perform a lead screening when it is clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial screening test. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

Laboratory procedures, continued

Blood Lead Concentration	Recommended Response
<10 ug/dL	**Rescreen at 24 months of age**
10 to 19 ug/dL	**Confirmation (venous) testing should be conducted within three months.** If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥10 ug/dL, environmental investigation will be offered.
20 to 44 ug/dL	**Confirmation (venous) testing should be conducted within 1 week.** If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years old with confirmed blood lead levels >20 ug/dL.
≥45 ug/dL	**The child should receive a venous lead test for confirmation as soon as possible**. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.

State Laboratory of Public Health for Blood Lead Screening

The State Laboratory Services of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results of specimens from children outside this age group need to contact the State Laboratory of Public Health at 919-733-3937.

Note: When the above laboratory tests are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

HEALTH CHECK SCREENING SCHEDULES

Periodic Screenings

The **preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP** are used to bill a periodic screening. (Refer to Health Check Billing Requirements on page 9.)

The schedule below outlines the recommended frequency of Health Check screenings dependent upon the age of the child. This schedule is based on recommendations for preventive pediatric health care.

Note: If an illness is detected during a Health Check screening, the provider may continue with the screening or bill a sick visit and reschedule the screening for a later date.

Periodicity Schedule

Within the first month	12 months	5 years
2 months	18 months	6 through 20 years
4 months	2 years	One screening every three years for children 6 years of age and older.
6 months	3 years	
9 or 15 months	4 years	

Interperiodic Screenings

The **preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP** are used to bill an interperiodic screening. (Refer to Health Check Billing Requirements on page 9 of the April 2003 North Carolina Medicaid Special Bulletin, Health Check Billing Guide.)

In addition to the periodicity schedule, interperiodic screenings are allowed in the following circumstances:

- When a child requires either a kindergarten or sports physical **outside** the regular schedule.
- When a child's physical, mental or developmental illnesses or conditions have already been diagnosed and there are indications that the illness or condition may require closer monitoring.
- When the screening provider has determined there are medical indications that make it necessary to schedule additional screenings in order to determine whether a child has a physical or mental illness or a condition that may require further assessment, diagnosis, or treatment.
- Upon referral by a health, developmental or educational professional based on their determination of medical necessity. Examples of referral sources may include Head Start, Agricultural Extension Services, Early Intervention Programs or Special Education Programs.

In each of these circumstances, the screening provider must specify and document in the child's medical record the reason necessitating the interperiodic screening.

Hearing and vision assessments are not required for an interperiodic screening. All other Health Check screening components must be performed during an interperiodic Health Check screening.